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Psychosocial treatment malls for people with intellectual disabilities

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Abstract

The provision of active treatment for people with intellectual disabilities has been seminal in the literature and in practice for a number of years. Active treatment has programmatic, financial, and legal ramifications for agencies and should be at the center of all appropriate treatment plans. The current work examines the use of psychosocial rehabilitation treatment malls to deliver active treatment to people with intellectual disabilities. The history, development, and implementation of these methods are discussed, with emphasis on services that are functional, meaningful, and portable. The importance of the therapeutic milieu is considered in context and discussed as the primary pathway to increased community integration. Finally, future directions of the treatment malls are considered.

Keywords: Active treatment; Treatment malls; Psychosocial rehabilitation; Therapeutic milieu

The assessment and treatment of persons with intellectual disabilities has been a controversial and emotionally charged topic for years. Prior to the 1960s, living settings for people with intellectual disabilities were primarily large, crowded, founded in a purely medical model, and people were kept from mainstream society (Blatt & Kaplan, 1966; Scheerenberger, 1983). In the early to mid 1960s, however, there were two sentinel events that changed treatment approaches for this population: (1) the emergence of the behavioral technology in psychology as a means of teaching life skills to persons with intellectual disabilities (ID) and; (2) publishing of the first studies indicating success in skills acquisition training for persons with ID (Dayan, 1964; Ellis, 1963). As a result of these developments, the *active treatment* model for persons with intellectual disabilities gained life, momentum, and remains to this day an integral element in the overarching treatment process.

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Active treatment is defined in a number of ways in current federal guidelines, research literature, and by treating clinicians. However, the term is usually characterized through language including learning opportunities (both planned and incidental), medical supports, and vocational/habilitation opportunities to increase independence, autonomy, and quality of life. Examples of skills programs that have been successfully implemented in the rubric of active treatment include social skills, communication skills, recreation/leisure activities, skills related to activities of daily living (ADLs), relationship/sexuality training, disease awareness/prevention, and vocational skills programs (Arnold-Reid, Schloss, & Alper, 1997; Bates, Cuvo, Miner, & Korabek, 2001; Browder & Grasso, 1999; Reid, 1982; Snell, 1987). Active treatment has been an evolutionary process that first came to the forefront nationally with the onset of federal investigations in the 1970s and later with federal laws and funding source regulations in the 1980s. Prior to that time, national surveys of institutions had focused largely on life-safety issues, physical plant/environmental issues, and issues pertaining to abuse/neglect. Since then, however, active treatment has been considered the centerpiece of service delivery in agencies funded with Intermediate Care Facility-Mentally Retarded (ICF-MR) dollars. This point has been reinforced in Civil Rights for Institutionalized Persons Act (CRIPA) investigations by the United States Department of Justice and has resulted in better assessment and treatment methodologies for the population (Ellis, 1982).

The delivery of active treatment should be at the center of services for people with intellectual disabilities. The current work considers the systems of active treatment at Pinecrest Developmental Center (PDC), an ICF-MR located in central Louisiana. PDC serves approximately 540 people with ID. Roughly 90% of the residents function in the severe and profound level of intellectual disability. Systems will be discussed from a historical perspective as well as in terms of current practices. Attention is given to the Interdisciplinary Team process, scheduling, and implementation. Finally, future directions of the program with associated research implications will be considered.

1. History

As mentioned earlier, the focus of Title XIX standards on active treatment changed the focus of agencies serving individuals with ID. In the beginning, PDC initiated these active treatment standards through residential staff implementing active treatment programs in the individual home setting. Although this was an improvement in the provision of active treatment, this structure allowed individuals little variety in their day-to-day activities and even less opportunity to experience training and practice skills in real life settings. The deficit in this structure was highlighted at the outset of a U.S. Department of Justice review of PDC. The structure was subsequently modified based on results of the review and similar recommendations to ICF/MR facilities across the country. At that time, PDC initiated off home day program activities. Initial implementation consisted of little more than moving the same training activities to a different location. Individuals remained with the same group of peers and the same staff as they were accustomed to in the residential setting, and simply moved to a different location for part of the day. Although this demonstrated improvement compared to past treatments, it lacked many critical elements needed for successful treatment.

During the time of the off home day programming initiative, PDC was divided into multiple administrative units consisting of approximately 150 people living in each unit area. Day program structure and system specifics were designed via the individual unit leadership resulting in a fragmented facility system for the delivery of day program services. The system of multiple units split the resources across many different programs with no opportunity to pool resources or